STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPL	ETED
		155019	B. WIN			02/10/2	011
			D. 11111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER	S.			CURRY PK		
GARDEN	I VILLA		BLOOMINGTON, IN47403				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000	This visit was for	r the Recertification and					
1 0000	State Licensure S						
	State Licensule S	Survey.					
	Survey dates: February 7, 8, 9 and 10,						
	2011						
	F 11'4 1	000007					
	Facility number-						
	Provider number-155019						
	AIM number-100	AIM number-100275040					
	Survey team:						
	Marla Potts, RN,	, TC					
	Melinda Lewis, l	RN (February 7, 8 and 9,					
	2011)						
	Sharon Whitema	n, RN					
	Amy Wininger, I	·					
	, ,						
	Census bed type:						
	SNF: 13						
	SNF/NF: 189						
	Total: 202						
	10141. 202						
	Census payor typ	ne.					
	Medicare: 26						
	Medicaid: 130						
	Other: 46						
	Total: 202						
	Sample: 30						
	Theses deficienc	ies also reflect state					
I A DOD ATOR	L DIDECTORIS OF PROV	/INED/CITODITED DEDDECENTATIVE'S CIC	NIATURE.		TITI E		(V6) DATE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155019			(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR' COMPLETE B. WING			
NAME OF F	PROVIDER OR SUPPLIEF	 	STREET	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
GARDEN			I	S CURRY PK MINGTON, IN47403		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	.D BE	(X5) COMPLETION DATE
	findings in accor	dance with 410 IAC 16.2.				
	_	completed on February				

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	JLTIPLE CC	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING		COMPL	ETED
		155019	B. WIN			02/10/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				CURRY PK		
GARDEN	I VII I A				IINGTON, IN47403		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	·		DATE
F0157		review and interview, the	F01	57	It is the policy of Garden Villa t		03/02/2011
SS=D	facility failed to	ensure the physician was			immediately inform the resider consult with the resident's	it,	
	notified promptly	when a resident was			physician; and if known, notify	the	
	found on the floor and complained of				residents legal representative		
	right shoulder pain for 1 of 30 residents				an interested family member		
	reviewed for physician notification in the				when there is a need to alter		
					treatment significantly such as		
	sample of 30. Resident #201.				need to discontinue an existing	3	
	D' 1' ' 1 1				form of treatment due to to		
	Findings include: The clinical record for Resident # 201 was				adverse consequences, or to commence a new form of		
					treatment.Garden Villa submits		
					the following action as evidence		
	reviewed on 2/7/	11 at 2:30 P.M. The			of its commitment to compliance		
	record indicated	Resident # 201 had			with regulatory requirements.l.		
	diagnoses that in	cluded but were not			What corrective action(s) will b		
	_	ovascular accident			accomplished for those reside		
		d senile dementia. The			found to have been affected by		
					the deficient practice?Residen #201 was followed by an	·	
	-	Data Set] assessment,			orthopedic physician and thera	nv	
	·	ndicated Resident # 201			was started when orthopedic	٠,٢٧	
		aired cognition. Resident			physician cleared resident to		
	# 201 required su	pervision with bed			begin and is still currently work	king	
	mobility and toil	et use. Resident # 201			with therapy at this time. Follow		
	required limited	assistance of one with			up appointment was completed		
	transfers. Reside	nt # 201 had not fallen			by orthopedic physician. Resid		
	since the last asso	essment			#201 has resumed to previous functional level. II. How other		
	Silico tilo last ass				residents having the potential	to	
	The Nurses Note	s, dated 1/12/11 at 4:00			be affected by the same deficie		
					practice will be identified and		
		'Res[resident] roommate			what corrective action(s) will be	e	
		er and said Res fell. Res			taken?All Residents have the		
		ight on floor in room.			potential to be affected by this		
		landed on R [right]			practice. In service training wa		
	shoulder. Res ref	fused to allow ROM,			completed with all licensed sta regarding immediate notification		
	grips et strength	strong and equal bilat			to physician of any suspected	/ ¹¹	
		omplains of R shoulder			injuries/change in condition. III		

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155019	A. BUI	LDING		02/10/2011	
		133019	B. WIN			02/10/2011	
NAME OF F	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
GARDEN	JVIIIA			1	CURRY PK /INGTON, IN47403		
		TATEMENT OF DEPLOYENCIES			1	(1/5)	
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION	
TAG	*	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	DATE	
	pain et PRN [as r	needed] Tylenol given at			What measures will be put into)	
	3:45 AM"				place or what systemic change	es	
					will be made to ensure the deficient practice does not		
	The Nurses Notes, dated 1/12/11 at 7:00				recur?Any suspected		
	A.M., indicated '	'Res seen by CNA using			injury/change in condition will		
	both arms to pusl	h self in w/c down			called to a physician, not faxed		
	hallway. faxed D	or (name) about fall et to			The on duty nurse will notify the on call nurse of any falls/change		
	ask for x-ray of F	R shoulder."			in condition. Together they will	- I	
					determine that all needs have		
	The Nurses Note	es, dated 1/12/11 at 12:30			been met and all protocols have been followed.IV. How correct		
	P.M., indicated "N.O. [new order] recd				action(s) will be monitored to	uve	
	[received] 1. May	y xray R shoulder.			ensure the deficient practice w	vill	
	(Name) to obtain	xray today"			not recur?The on duty nurse w	/ill	
					notify the on call nurse of any falls/change in condition.		
		es, dated 1/13/11 at 4:00			Together they will determine the	nat	
		'R shoulder xray results			all needs have been met and a	all	
		impacted humeral neck			protocols have been		
		displacement. Results			followed.Monthly a report will be given to Quality Assurance	Je	
	faxed to Dr (nam	ne)."			regarding the physician		
		1 . 144044 20			notification compliance gather		
		es, dated 1/13/11 at 7:30			by the ADON to be monitored the DON. This will be a 3 mon		
		'No c/o's of pain during			consecutive report then review		
		cked on q [every] 2 hours.			for a change to quarterly revie		
	`	ame) for stronger pain			V. Systemic changes will be		
	med [medication] secondary to fracture."			completed by: 3/2/11		
	The Nurses Nets	es, dated 1/13/11 at 9:30					
		'Call placed to (physician					
	•	s time and recd N.O. 1.					
	· · · · · · · · · · · · · · · · · · ·	o for R humeral fx					
		appt [appointment] at					
	(clinic name)"	արթե լարբծուսուծույ ան					
	(chine nume)						
					ļ		

l	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155019	(X2) MULTIPLE CC A. BUILDING B. WING	NSTRUCTION	(X3) DATE COMP 02/10/2	LETED
NAME OF F	PROVIDER OR SUPPLIEF	** }	1100 S	ADDRESS, CITY, STATE, ZIP CODE CURRY PK MINGTON, IN47403	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
	Nursing, on 2/9/indicated the state timely with contour The Director of acility policy are in a Resident's C 3/04 at that time "The nurse supporting the residence on-call physicians."	with the Director of 11 at 12:40 P.M., ff should have been more acting the physician. Nursing provided the ad procedure for Change condition or Status, dated are revisor/charge nurse will art's attending physician or a when there has been: An alent involving the				

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155019	CATION NUMBER: A BUILDING		
NAME OF P	ROVIDER OR SUPPLIER		STREET A	ADDRESS, CITY, STATE, ZIP CODE	
GARDEN	I VILLA			CURRY PK 1INGTON, IN47403	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON (X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 155019 02/10/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1100 S CURRY PK **GARDEN VILLA BLOOMINGTON, IN47403** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) PREFIX PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE It is the policy of Garden Villa to F0282 Based on observation, interview and F0282 03/02/2011 provide services by qualified record review, the facility failed to ensure SS=D persons in accordance with each Resident #38 and Resident #26 was resident's written plan of care. transferred according to the plan of care, Garden Villa submits the following action as evidence of its in that both residents experienced falls for commitment to compliance with 2 of 17 residents reviewed for following regulatory requirements.l. What the plan of care for falls in a sample of 30. corrective action(s) will be accomplished for those residents Findings include: found to have been affected by the deficient practice?Resident #38, a long term resident since 1. Resident # 38 was identified during 2002, has not had any initial tour on 02/07/11 at 9:30 A.M., by further incidents related to staff Unit Manager #1 as not interviewable and not following the plan of care appropriately since May having a history of falls. 2010. Resident #38 remains injury free and is monitored by The clinical record of Resident #38 was facility staff daily due to altered reviewed on 02/07/11 at 1:00 P.M. safety awareness. Resident #26 has not had any further incidents with injuries since The residents' diagnoses included, but 1/12/11. Resident #26 remains were not limited to, Alzheimer's injury free and is monitored by dementia, History of compression facility staff daily due to altered safety awareness. In service fractures T11 & T12 [Thoracic vertebra training has been completed with 11 & Thoracic vertebra 12], and all nursing staff regarding the osteoporosis. identified residents. II. How other residents having the potential to be affected by the same deficient The resident was observed on 02/07/11 at practice will be identified and 12:20 P.M., to be sitting in a wheelchair. what corrective action(s) will be taken?All Residents have the Nurses Notes, dated 05/07/10 at 11:10 potential to be affected by this practice. In service training has A.M., indicated, "...Found res [resident] been completed with all nursing lying on left side with back to toilet. staff regarding following care CNA [Certified Nursing Assistant] stated plans as directed. III. What that res legs buckled during transfer to measures will be put into place or

Facility ID:

STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DA			(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	DING		COMPL	ETED
		155019	B. WIN			02/10/2	011
		ll	P. (111)		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			CURRY PK		
GARDEN	N VILLA			BLOOM	MINGTON, IN47403		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG	+	LSC IDENTIFYING INFORMATION)	-	TAG			DATE
		NA lowered res to the			what systemic changes will be made to ensure the deficient		
		ses Notes, dated 05/24/10			practice does not recur?Curre	ntlv	
	at 7:10 P.M., indicated, "Resident sitting				during orientation all nursing s	•	
	up against wall. CNA voiced 'She is not				are educated on the need to		
	hurt, I lowered h	er to the floor. We both			follow care plans as directed a		
	slipped. I was trying to help her'Staff				education continues throughouth of their employment		
	education done of	of her being a 2 person			the length of their employment service training has been	. 111	
	liftIntervention	n decided upon between			completed with all nursing stat	f	
	this writer and R	N on call-educate Station			regarding following the care pl	an	
	2 staff of residen	it being 2 person assist."			as directed.IV. How corrective	•	
		6 1			action(s) will be monitored to	.iii	
	A care plan, date	ed 10/25/06, for the			ensure the deficient practice w not recur?Director of Nursing		
	problem of "Tra	•			ADON will ensure that during		
	_	t X2 due to arthritis"			nursing staff orientation,		
	included, but wa				education is completed regard	ing	
	•	"keep call light within			the following of care plans as directed. Quality Assurance will		
		-					
	reach and answe	r prompuy			be given a report monthly regarding education. This will be		
					a 3 month consecutive report		
		otential for falls indicated			then reviewed for a change to		
		been lowered to the floor			quarterly review V. Systemic		
	1 -	throom on 05/07/10 and			changes will be completed by:		
	05/24/10. The in	terventions included, but			3/2/11		
	were not limited	to, "05/07/10 Verbal					
	counseling to sta	iff for following					
	assignment shee	ts05/20/10 Memo in					
	care tracker for f	Collowing assignment					
	sheets."						
	In an interview v	with Unit Manager #1 on					
	02/07/11 at 1:20 P.M., she indicated, "The 05/07/10 fall was because the resident						
		n assist and there was					
	_						
	only one person	in there and the $05/24/10$					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155019			(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED 02/10/2011		
NAME OF I	PROVIDER OR SUPPLIEF	2	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 S CURRY PK BLOOMINGTON, IN47403				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DN COMPL		
	there. I put it on 05/20/10 so ever	ng, only one person in the care tracker on yone would see it. It was who got pulled to my					
	initial tour on 02	6 was identified during /07/11 at 9:15 A.M. by as not interviewable, ent fall.					
		ord of Resident #26 was 08/11 at 3:00 P.M.					
	were not limited arthroplasty, osto	agnoses included, but to, "left shoulder eoporotic compression L2 ertebrae 2 & 3], and					
		s observed on 02/08/11 at lying in a low bed with a					
	01/07/11, includ	Imission orders, dated ed, but were not limited p with assistance."					
	Assignment She Manager #1 on (fied Nursing Assistant] et provided by Unit 02/07/11 at 9:00 A.M., ident required extensive				-	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155019		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE S COMPL	ETED	
		100019	B. WIN		DDDDGG GUTY GTUTT TO SON	02/10/2	UII
NAME OF F	PROVIDER OR SUPPLIER			1	DDRESS, CITY, STATE, ZIP CODE		
GARDEN			BLOOMINGTON, IN47403				
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ΓE	DATE
		transfers, low bed with					
		nd non-skid socks.					
	Nurses Notes, dated 01/12/11 at 07:35						
A.M., indicated, "This writer saw CNA at							
	1	resident] room waving for					
		om. I observed res sitting					
		her left leg straight out					
		d her right leg and knee					
		owards her bottomHer e side of the bed. She					
		ack of my head.' Res has					
		e egg swelling to the back					
	middle area of he						
	iniddic area or iid	51 11 00U					
	A care plan, date	d 01/07/11, indicated the					
		etential for falls. The					
	1	luded, but were not					
		sive assist of 1 for					
	transfers, low be	d, and scoop mattress. A					
	care plan, update	ed 01/12/11, included,					
		ed to, an intervention					
	"staff education of						
	assignment sheet						
		'.d TT '. 3.4 #4					
		with Unit Manager #1, on					
		P.M.,,. she indicated, the					
		t in a low bed, she was in Staff forgot to lower					
		tion was staff education					
	1	because they didn't do					
	that"	occurse they didn't do					

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155019				SURVEY LETED 2011
NAME OF F	ROVIDER OR SUPPLIER		1100 S	ADDRESS, CITY, STATE, ZIP CODE CURRY PK IINGTON, IN47403	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE
IAU	Nurses Notes dan P.M., indicated, res. sitting in a h 2 nurse. Nurse st her knees while a with walker." A care plan for frindicated the resiber head. The into 02/01/11, include to, "staff education warning to staff and interview warning to staff and was able to get unwalker was in resign low position,"	ted, 02/01/11 at 7:00 "Called to Station 2. Saw allway chair with Station ated that res had fallen to ambulating independently alls updated 02/01/11 ident had fallen and hit terventions, dated ed, but were not limited on in caretrackerwritten assisting resident." with Unit Manager #1, on P.M., she indicated, "She p by herself because the ach and the bed was not I gave the CNA's a verbal following the assignment	IAG	DEPLEACELY		DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155019	B. WIN			02/10/201	1
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			l .	CURRY PK		
GARDEN					MINGTON, IN47403		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	OMPLETION DATE
F0315			F03		It is the policy of Garden Villa	-0	3/02/2011
		ation, interview, and	1 103	13	provide a resident with urinary		13/02/2011
SS=D		e facility failed to ensure			incontinence appropriate		
		theter handling while			treatment and services to prev	ent	
	providing care fo				urinary tract infections and to		
		ary catheters in a sample			restore as much normal bladd function as possible. Garden V		
	of 30. (Resident #	#66)			submits the following action as		
					evidence of its commitment to		
	Findings Include:	•			compliance with regulatory		
					requirements.l. What corrective		
	On 02/07/11 at 12:30 p.m., Resident #66 was observed seated in the dining room				action(s) will be accomplished those residents found to have	TOF	
					been affected by the deficient		
	eating lunch. Res	sident #66 was observed			practice?Resident #66 had fol	ey	
	to have a Foley (1	urinary) catheter with the			catheter for an extended perio		
	catheter tubing di	ragging on the floor.			time at home due to a diagnos	is	
					of urinary retention before admitting to the hospital. Residual	lent	
	On 02/07/11 at 12	2:33 p.m., CNA #3 was			#66 was admitted to this facilit		
	observed to prope	el Resident #66's			on 1/25/11 from the hospital w		
		to the resident's room.			a foley catheter and a diagnos		
	The resident's uri	nary catheter tubing was			of UTI. Resident #66 continue		
	observed to drag	-			antibiotic therapy for UTI. In or to ensure proper catheter	der	
	cosor, ou to urug	110011			handling a velcro strap was us	ed	
	On 02/07/11 at 1	2:35 p.m., CNA #3 and			to form a loop in the catheter	- "	
	LPN #2 were obs	-			tubing thus keeping it from		
	Resident #66 from				reaching the floor. II. How oth		
		resident's bed. CNA #3			residents having the potential be affected by the same defici		
		remove the wheelchair			practice will be identified and	5111	
					what corrective action(s) will b	e	
	_	noring the urinary			taken?All residents have the		
		n the floor. During the			potential to be affected by this		
	·	was observed to hand			practice. For all residents that have a foley catheter, to ensur	_	
	_	age bag to LPN #2. LPN			proper catheter handling, a ve		
		to hold the drainage bag			strap was used to form a loop		
	•	dent's lap. Amber			the catheter tubing thus keepii	ng it	
	colored urine was	s observed to back flow			from reaching the floor. In serv	vice	

	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
ANDILAN	OF CORRECTION	155019	1	LDING		02/10/20	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	02/10/2	
NAME OF F	PROVIDER OR SUPPLIER				CURRY PK		
GARDEN				1	MINGTON, IN47403		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
	*				CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	
PREFIX TAG	in the tubing. LF place the urinary onto the floor. On 02/07/11 at 1 Therapist #1 was Resident #66 from wheelchair to a fl Therapist #1 was resident's urinary trouser pocket du On 02/08/11 at 9 was observed aslighted resident's urinary were observed to On 02/08/11 at 10 CNA #2 were observed to #66 a bed bath. If CNA #2 was observed seat able. The resident tubing was observed seat table. The resident tubing was observed floor.	herapy table. Physical sobserved to hang the drainage bag onto his uring the transfer. 10 a.m., Resident #66 eep in bed. The drainage bag and tubing be dragging on the floor. 0:40 a.m., LPN #1 and served to give Resident During the bed bath, erved to place the drainage bag between to hold the drainage bag		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	l per vice l per e e e e e e e e e e e e e e e e e e	COMPLETION DATE
	at 2:20 p.m., indi	cated facility policy was					

000007

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		155019	B. WIN			02/10/2	011
NAME OF F	PROVIDER OR SUPPLIER		 	1100 S	DDDRESS, CITY, STATE, ZIP CODE CURRY PK IINGTON, IN47403		
(X4) ID		TATEMENT OF DEFICIENCIES	T	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
		rainage bags and tubing bladder and off the floor.	ó				
	Review of Resident #66's clinical record on 02/08/11 at 10:17 a.m., indicated the following:						
	included, but we	I diagnoses which re not limited to, right hip movement disorder, and					
	"Risk for UTI (• • •					
	"Risk for UTI du catheter)Currer	d 01/25/11, indicated, e to (Foley nt for UTICipro 500 mg daily)Maintain catheter					
	provided by Unit at 2:20 p.m. The purpose of this prinfection of the retractThe urinary held or positione at all times to pre-	Catheter Care" was Manager #2 on 02/08/11 policy indicated, "The rocedure is to prevent esident's urinary y drainage bag must be d lower than the bladder event the urine in the age bag from flowing					

000007

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155019			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/10/2011	
NAME OF F	PROVIDER OR SUPPLIER	1	1100 S (DDRESS, CITY, STATE, ZIP CODE CURRY PK INGTON, IN47403	,		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (EACH DEFICIENCY MUST BE PERCEI REGULATORY OR LSC IDENTIFYING IN	DED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
TAG	back into the urinary bladderB catheter tubing and drainage bag off the floor. 3.1-41(a)(2)	e sure the	TAG	DEFICIENCY)	PKIALE	DATE	

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) I			(X3) DATE SU	3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIIII	A. BUILDING			COMPLETED	
		155019	B. WIN			02/10/201	11	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF F	PROVIDER OR SUPPLIER				CURRY PK			
GARDEN	J \/II Ι Δ				MINGTON, IN47403			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	re (COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)		DATE	
F0323			F03	23	It is the policy of Garden Villa	to (03/02/2011	
SS=D	Based on observa	ation, interview, and			ensure that the resident			
	record review, th	e facility failed to ensure			environment remains as free f			
	I	prevent falls were			accident hazards as is possible and each resident receives	е,		
	_	lemented, in that staff			adequate supervision and			
	1				assistance devices to prevent			
		he care plan resulting in			accidents. Garden Villa subm	its		
	· ·	residents reviewed for			the following action as evidence			
	1	le of 30. Resident #215,			of its commitment to complian		l	
	#38 and 26.				with regulatory requirements.I.			
					What corrective action(s) will be			
	Findings include:				accomplished for those reside			
	i mamga meraac	•			found to have been affected by	, I		
					the deficient practice?Residen	ts		
		10 5 11 1/4015			#215, 26, and 38 have all had their care plans reviewed and			
		record for Resident # 215			updated so all fall interventions			
	was reviewed on	2/7/11 at 3:00 P.M. The			are resident specific and	"		
	record indicated	Resident # 215 had			appropriate. II. How other			
	diagnoses that in	cluded but were not			residents having the potential	to		
	_	mer's disease with senile			be affected by the same defici-	ent		
		[DS [Minimum Data Set]			practice will be identified and			
		=			what corrective action(s) will b	e		
		d 10/29/10, indicated			taken?All residents have the			
		ad severely impaired			potential to be affected by this			
		ent # 215 required			practice. All resident care plan with new fall interventions since			
	extensive assistar	nce of two with bed			2/1/11 have been reviewed an			
	mobility, transfer	rs and toilet use.			updated to be resident specific	I .		
		equired limited assistance			and appropriate. In service			
		ulation, and had a fall			training was completed with al	ı		
	with major injury				nursing staff regarding the nee			
		since the last			to follow care planned		l	
	assessment.				interventions as directed for al			
					residents. III. What measures			
	A care plan, date	d 2/5/09 and updated on			be put into place or what syste		l	
	1/17/11, indicated	d a problem of "Risk for			changes will be made to ensur			
	· ·	d by history of falls,			the deficient practice does not recur?In service training was			
	multiple risk fact	-			completed with all nursing staf	_f		
	manupic risk ract	to to the total to			completed that all flatoning state	.		
					l			

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ONSTRUCTION	(X3) DATE COMPI	
		155019	A. BUII B. WIN			02/10/2	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	1	
NAME OF I	PROVIDER OR SUPPLIER			1	CURRY PK		
GARDEN					MINGTON, IN47403		
(X4) ID		FATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
	independent with				regarding the need for reside specific fall interventions. IV.	nt	
	transfers and locomotion on and off unit, antidepressant and antipsychotic therapy.				How corrective action(s) will be	ре	
		1 5			monitored to ensure the defic		
		out of rocking chair in ventions included "Have			practice will not recur?Every to will be reviewed by the on du		
		articles within easy reach.			nurse and the on call nurse.		
	1	proper and non slip			ADON will then review all		
		rage resident to use			applicable paper work regard the fall and interventions. A	ıng	
		tive devices properly.			monthly report will be given to)	
	Keep walkways f	ree of clutter including			Quality Assurance regarding	I/ON	
	keppin(sic) DR enterance (sic) open. Complete and review fall risk assessment				accidents/incidents by the AD to be monitored by the DON.		
					Systemic changes will be		
	1 ^ -	er each fall. May have			completed by: 3/2/11		
	high/low bed with	•					
		et (antidepressant) 150					
	•] QD [everyday]. Ensure					
		. Call light in reach and					
	answer promptly.	east every 2 hours. Non					
		[night] night light in					
		cated staff on picking up					
		or redirecting. To utilize					
		alking outside with staff.					
	~	ads from dresser in					
	lounge. UA+ [uri	nalysis], B/P q [every]					
	shift x [times] 3 d	lays."					
	The Fall Risk Ass	sessment, dated 7/16/10,					
	indicated a score	of 14. The form					
	indicated "Total s	score above 10 represents					
	HIGH RISK."						
	The Fall Risk Ass	sessment, dated 9/3/10,					
FORM CMS-2	2567(02-99) Previous Version	ns Obsolete Event ID:	SMSW1	Facility 1	ID: 000007 If continuation	sheet Pa	ge 17 of 42

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING		COMPLETED	
		155019	B. WIN	G		02/10/2	011
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE	-	
OADDEA	13/11/14			I	CURRY PK		
GARDEN	N VILLA			BLOOM	MINGTON, IN47403		_
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	` `	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
IAG	+	LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCE)		DATE
	indicated a score						
		score above 10 represents					
		he Ongoing/ periodic					
		3/10 indicated "Res					
	1 ^ ^	ther res's foot at entrance					
		om] et fell on R side.					
		irs away from entrance to					
	nall/DK to make	area more open."					
		1 . 110/10/10 6 20					
		es, dated 10/18/10 at 6:30					
		'Staff heard chairs					
	_	ne floor et [and] noted res					
	1	side holding head. Res					
		p from table at dinner.					
		s et noted bump to back					
		s c/o [complaints of] pain					
		staff was checking ROM					
	1	a]. MD et POA [power of					
	1 **	d. N.O. [new order] rec'd					
	I	to ER [emergency room]					
	for evaluation et	tx [treatment]."					
		es, dated 10/18/10 at 8:30					
	1	'Res ret [returned] to					
	1 -	ne with dx [diagnosis of]					
	simple L [left] po	elvis fx [fracture]"					
	The Fall Risk As						
	1	ted a score of 15. The					
		Total score above 10					
	represents HIGH						
		c evaluation for 10/18/10					
	indicated "Res fe	ell onto L side in DR. Res					

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
THEFTERN	or connection	155019	A. BUILDING		02/10/2011
			B. WING	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER			S CURRY PK	
GARDEN			BLOO	MINGTON, IN47403	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B	
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	
1110		supper and had got up.	1710		DATE
	-	n. Sent to ER [emergency			
	• .	neuro checks. 1:1 [one to			
	-	as nursing measure on			
	return from ER."				
	retuin from Exc.				
	The Fall Risk As	sessment, dated			
	10/29/10, indicat	ed a score of 16. The			
	form indicated "	Total score above 10			
	represents HIGH	RISK."			
	The Nurses Note	s, dated 11/25/10 at 4:30			
		'Res found sitting up on			
		een door et w/c at 152			
		as in bed at 140 AM [sic]			
		ked on her. At 150 AM			
		A walked down hallway			
		or to her room closed			
	-	n earlier and went in and			
		noved all extremities and			
	_	ne of fall. Noted 0.6 cm x			
		with L [left] elbow (sic).			
	• •	ned with this fall or earlier ior on earlier shiftRes			
		nt to lounge in recliner			
	facing nurses des	_			
	supervision"	ok for closer			
	Saper (Islon				
	The Fall Risk As	sessment, dated			
		ed a score of 21. The			
		Total score above 10			
	represents HIGH				
	•	c evaluation for 11/25/10			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155019			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 02/10/2011	
		155019	B. WING			02/10/2	011
NAME OF E	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 S CURRY PK BLOOMINGTON, IN47403				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	.ΤΕ	(X5) COMPLETION DATE
TAG	indicated "Res gow/c into BR, four Res brought to lot for closer supervitimes." The fall care plant updated on 1/17/of hip savers on a 11/25/10. The Nurses Note time, indicated "con the floor on he apparently got O over the mattress attempted to stambottom. Res had [right] elbow are 0.25 x [by] 0.25 noted" The Nurses Note P.M., indicated "side in bathroom gone to bed with room until res has states was going	ot up unassisted and took and sitting on floor in BR. Dounge in recliner resting ision. Hip savers at all and the intervention at all times initiated on the second by CNA sitting the second by CNA sit		TAG		NE .	DATE
	(distal)Noted resocks. Res was a	es had removed nonskid ssisted back into w/c nd brought to lounge to					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155019		(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION	COMP	(X3) DATE SURVEY COMPLETED 02/10/2011	
NAME OF I	PROVIDER OR SUPPLIEF	!!	STREET A 1100 S	ADDRESS, CITY, STATE, ZIP CODE CURRY PK MINGTON, IN47403	·	
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROI DEFICIENCY)	BE	(X5) COMPLETION DATE
	form indicated "represents HIGH Ongoing/periodi indicated "Res g in to BR. Found had removed not to lounge for clo supervision whill The fall care pla updated on 1/17/ of constant superplan initiated on The Nurses Note P.M., indicated 'up in front of w/ area at the supper witnessed res ris put her one hand attempted to place another res. w/c caught res before floor. Res has sn sm [small] redde middle of back. In notedIncident if	ted a score of 21. The Total score above 10 I RISK." The c evaluation for 12/12/10 ot up unassisted et went lying L side. Res assessed askid socks. Res brought ser supervision. Constant e up." n, dated 2/5/09 and /11, had the intervention rvision while up, toileting 12/13/10. es, dated 12/19/10 at 8:30 Writer found res sitting c on st (number) lounge or table. Activity Assistant e up from her w/c. She on her own w/c et ce her other hand on but missed. Visitor e her head could hit the hall abrasion/more of a med area on her R [right]				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155019	B. WIN			02/10/2	011
NAME OF I	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 S CURRY PK BLOOMINGTON, IN47403				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	form indicated "represents HIGH Ongoing/periodic indicated "Res go her hand on her wanother res w/c b floor. Visitor kep head on the floor unable to get to resonant supervised dine." The fall care plan updated on 1/17/of Walk to dine pDR and sit in reg on 12/20/10. The Nurses Note P.M., indicated "room sitting on bRes had been in was sitting in rocout of rocking chinjuries" The Fall Risk As indicated a score indicated "Total services and the services are represented by the services are represented b	ed a score of 15. The Total score above 10 RISK." The c evaluation for 12/19/10 of up out of w/c. Placed w/c et her other hand on out missed et slid to the c tres from hitting her c. AA [activity assistant] es in time. Res has sion while up. Walk to an dated 2/5/09 and 11, had the intervention program- to walk res to a [regular] chair initiated s, dated 1/14/11 at 11:45 Res found in floor in her outtocks by rocking chair. W/c and went in room and oking chair and pad came tair onto floor. No					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
THEFTERN	or colucterion	155019	A. BUILDING B. WING		02/10/2011
				ADDRESS, CITY, STATE, ZIP CODE	
	PROVIDER OR SUPPLIER		1100 S	CURRY PK	
GARDEN	I VILLA		BLOOM	MINGTON, IN47403	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI	(X5)
PREFIX TAG		CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
		14/11 indicated "Res fell			
	out of rocking ch	nair in room no injury			
	Dycem to rockin	g chair staff education."			
The fall care plan, dated 2/5/09 and					
	_				
	•	11, had the intervention king chair under pad, staff			
	education initiate	-			
		vith the Alzheimer's Unit			
	_	/11 at 12:10 P.M., she			
		ff education provided on			
		nuse one of the aides had in her room unattended			
		have known she was on			
	-	sion and the staff should			
	have known bett				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING		COMPL	ETED
		155019	B. WING			02/10/2	011
			D. 11111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				CURRY PK		
GARDEN	I VILLA				MINGTON, IN47403		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		DATE
F0323	2. Resident # 3	8 was identified during	F032	23	It is the policy of Garden Villa t	:0	03/02/2011
SS=D	initial tour on 02	/07/11 at 9:30 A.M. by			ensure that the resident	rom	
	Unit Manager #1 as not interviewable and				environment remains as free for accident hazards as is possible		
	having a history				and each resident receives	C ,	
					adequate supervision and		
	The elipical reco	rd of Resident #38 was			assistance devices to prevent		
					accidents. Garden Villa submi	its	
	reviewed on 02/0	07/11 at 1:00 P.M.			the following action as evidence		
					of its commitment to compliand		
		agnoses included, but			with regulatory requirements.l.		
	were not limited	to, Alzheimer's			What corrective action(s) will be accomplished for those reside		
	dementia, Histor	y of compression			found to have been affected by		
	fractures T11 & 7	Γ12 [Thoracic vertebrae			the deficient practice?Residen		
	11 & Thoracic ve	-			#215, 26, and 38 have all had		
	osteoporosis.	7,			their care plans reviewed and		
	osteoporosis.				updated so all fall interventions	S	
	The medial and	s observed on 02/07/11 at			are resident specific and		
					appropriate. II. How other		
	12:20 P.M. to be	sitting in a wheelchair.			residents having the potential be affected by the same deficient		
					practice will be identified and	EIIL	
	The most recent	MDS [Minimum Data			what corrective action(s) will b	e	
	Set Assessment],	dated 11/09/10,			taken?All residents have the		
	indicated the resi	dent was unable to stand			potential to be affected by this		
	without physical	help. The MDS further			practice. All resident care plan		
		dent was severely			with new fall interventions since		
		ired and required			2/1/11 have been reviewed an		
		of two persons for			updated to be resident specific and appropriate. In service	,	
		of two persons for			training was completed with al	ı	
	transfers.				nursing staff regarding the nee		
					to follow care planned		
	• •	d 10/25/06, for the			interventions as directed for al		
	problem of "Tra	nsfers with ext.			residents. III. What measures		
	[extensive] assist	X2 due to arthritis"			be put into place or what syste		
	included, but was	s not limited to,			changes will be made to ensur the deficient practice does not		
	interventions of "keep call light within				recur?In service training was		
	reach and answer	-			completed with all nursing staf	f	
		r			,		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	155019	A. BUI	LDING		02/10/2011	
		133019	B. WIN			02/10/2	011
NAME OF I	PROVIDER OR SUPPLIER			1	ADDRESS, CITY, STATE, ZIP CODE		
GARDEN	λ \/ΙΙ Ι Δ			1	CURRY PK /INGTON, IN47403		
					+		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	· ·	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE	DATE
	Nurses Notes dat A.M., indicated, lying on left side CNA [Certified Mathematical that res legs buck toilet et [and] CN floor." The Nurse at 7:10 P.M., indup against wall. On the slipped. I was tryeducation done on liftIntervention this writer and R 2 staff of residen A care plan for puther resident had by staff in the bath of 105/24/10. The intervention were not limited counseling to state assignment sheet care tracker for fisheets." The Fall Risk As 05/06/10 indicated "22". The Assession above 10 representations.	ted 05/07/10 at 11:10 "Found res [resident] with back to toilet. Nursing Assistant] stated kled during transfer to JA lowered res to the es Notes, dated 05/24/10 icated, "Resident sitting CNA voiced 'She is not er to the floor. We both ving to help her'Staff of her being a 2 person a decided upon between N on call-educate Station t being 2 person assist." otential for falls indicated been lowered to the floor throom on 05/07/10 and terventions included, but to, "05/07/10 Verbal			regarding the need for residen specific fall interventions. IV. How corrective action(s) will be monitored to ensure the deficie practice will not recur? Every fawill be reviewed by the on duty nurse and the on call nurse. To ADON will then review all applicable paper work regarding the fall and interventions. A monthly report will be given to Quality Assurance regarding accidents/incidents by the ADO to be monitored by the DON. A Systemic changes will be completed by: 3/2/11	e ent all / he ng	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155019		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/10/2011		
NAME OF PI	ROVIDER OR SUPPLIER		B. WING	STREET A	DDRESS, CITY, STATE, ZIP CODE	1 10,2	
GARDEN	VILLA			BLOOM	IINGTON, IN47403		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	02/07/11 at 1:20 05/07/10 fall was was a two person only one person i was the same thir there. I put it on to 05/20/10 so every different CNA's v unit." 3. Resident # 26 initial tour on 02/0 Unit Manager #1 and having a rece The clinical recor reviewed on 02/0 The residents' dia were not limited arthroplasty, oste & L3 [Lumbar ve osteoarthritis." The resident was 3:00 P.M. to be I scoop mattress. Nurses Notes, da A.M., indicated,	P.M. she indicated, "The secause the resident assist and there was in there and the 05/24/10 mg, only one person in the care tracker on yone would see it. It was who got pulled to my was identified during /07/11 at 9:15 A.M. by as not interviewable, ent fall. rd of Resident #26 was 08/11 at 3:00 P.M.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				ULTIPLE CO	(X3) DATE SURVEY COMPLETED		
		155019	A. BUI B. WIN	LDING IG		02/10/20	011
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				CURRY PK		
GARDEN				1	MINGTON, IN47403		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	· ·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		om. I observed res sitting					
	on the floor with	her left leg straight out					
	in front of her and her right leg and knee						
	bent backwards t	owards her bottomHer					
	walker was at the	e side of the bed. She					
	stated 'I hit the ba	ack of my head.' Res has					
	a large size goose	e egg swelling to the back					
	middle area of he	er head"					
	A care plan, dated 01/07/11, indicated the resident had a potential for falls. The						
	•	luded, but were not					
		sive assist of 1 for					
		d, and scoop mattress. A					
		-					
		d 01/12/11 included, but					
		o, an intervention "staff					
		bed and assignment					
	sheet."						
	In an interview w	vith Unit Manager #1 on					
	02/08/11 at 3:30	P.M., she indicated, the					
	resident "was not	t in a low bed, she was in					
		Staff forgot to lower					
	_	tion was staff education					
	*	because they didn't do					
	that"	and the state of t					
	Nurses Notes da	ted 02/01/11 at 7:00					
	· ·	"Called to Station 2. Saw					
		allway chair with Station					
	_	3					
		ated that res had fallen to					
		ambulating independently					
	with walker."						
			L				

	OF OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155019	(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION	(X3) DATE COMP 02/10/2	LETED
NAME OF I	PROVIDER OR SUPPLIER	! R	1100 S	ADDRESS, CITY, STATE, ZIP CODE CURRY PK MINGTON, IN47403	.	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
	indicated the resher head. The im 02/01/11, includ to, "staff educati warning to staff In an interview of 02/08/11 at 3:30 was able to get of walker was in rein low position, warning for not sheet." The Fall Risk As 01/07/11 indicate "18". The Assess of above 10 repromates above 10 repromates in low position, warning for not sheet."	es with emphasis on etyTo prepare for a ne if you need help to				

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155019	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION	COMI	(X3) DATE SURVEY COMPLETED 02/10/2011	
NAME OF P	PROVIDER OR SUPPLIER		1100 S	ADDRESS, CITY, STATE, ZIP COE CURRY PK IINGTON, IN47403	DE .		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APF DEFICIENCY)	CTION ULD BE PROPRIATE	(X5) COMPLETION DATE	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155019			(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 02/10/2011	
NAME OF P	ROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE	02/10/2	
GARDEN				1	MINGTON, IN47403		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Έ	(X5) COMPLETION DATE
F0333 SS=D	Based on intervier facility failed to do of significant me resident's medical pressure was not attending physicis medication being have been given, reviewed for medication being have been given, reviewed for medication being have been given, reviewed for medicated for the clinical reconstruction reviewed on 2/7/record indicated diagnoses that inclimited to demen MDS [Minimum dated 10/20/10, it had severely imp # 202 was independent of the clinical required suparambulation, and it had no falls. A Physician order but were not limit orders: "Norvasc	ew and record review, the ensure residents were free dication errors in that a tion to control her blood given as ordered by the an, resulting in the sheld when it should for 1 of 30 residents dication administration, 30. Resident #202	F03		It is the policy of Garden Villa to ensure that residents are free from any significant medication errors. Garden Villa submits the following action as evidence of commitment to compliance with regulatory requirements. I. Who corrective action(s) will be accomplished for those resident found to have been affected by the deficient practice? Resident #202's medication administration record has been revised to cleindicate when to administer or hold a medication. Resident 20 physician has been notified of medication errors that resulted November 2010. After review of Resident 202's record no furth medication errors have occurred since November 2010. II. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to affected by this practice. Any medications in question of beinheld must be reported to the Ron call for approval. In service training was completed with all medication administration staff regarding proper parameters for holding medications. III. What measures will be put into place what systemic changes will be made to ensure the deficient practice does not recur? Weekl all medication administration	n ne fits h at strong arly of second or second	03/02/2011
	pressure (the upp	er number of the blood			records, for residents that have	•	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
THEFTERN	or connection	155019		LDING		02/10/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			1	CURRY PK		
GARDEN				1	MINGTON, IN47403		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E	LETION ATE
IAG			-	IAG	parameters associated with a	D.F	AIE
	/3 -	s than] 100* and Atenolol			medication, will be reviewed b	,	
	50 mg take 1 tablet by mouth daily *Hold if P [pulse] < 60 or SBP < 100 check blood				nursing administration. Any		
					medications in question of bei	· 1	
		isinopril 20 mg take 1			held must be reported to the R on call for approval. The RN o		
	•	wo times a day *Hold if			call will keep a log of calls	'	
	SBP < 100."				received and approvals given.		
	The Nurses Note	s, dated 11/11/10 at 9:00			How corrective action(s) will be monitored to ensure the deficient		
		'Called by staff noted res			practice will not recur?Monthly	I	
		on floor on buttocks			report will be given to		
	noted hematoma on back of head res stated "I got dizzy and fell I hit my				Quality Assurance regarding the	ne	
					held medications and RN notification. This information w		
		plains of headacheB/P			be reported for 3 consecutive	""	
	178/74"	,			months then will be up for		
	170//1				quarterly review. V. Systemic		
	The Nurses Note	s, dated 11/11/10 at 1:30			changes will be completed by: 3/2/11		
		Medication error noted in			0/2/11		
		ood pressure medication)					
	`	ood pressure medication)					
	,	dated of 11/1, 11/5, 11/6,					
		, 11/11 when meds were					
		held and pulse and/or					
		within normal limits].					
	MD notified"						
	The November 2	010 Medication					
	Administration R	Record (MAR) indicated					
	on 11/1/10 at 8:0	0 A.M. the blood					
	pressure was 119	/51 with the Norvasc					
	held.						
	On 11/5/10 at 8:0	00 A.M. the blood					
	pressure was 116	5/56 with the Norvasc					
	held.						

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	DING COMPLETED		
		155019	B. WIN			02/10/2	011
NAME OF I	PROVIDER OR SUPPLIER	: }	·	1	ADDRESS, CITY, STATE, ZIP CODE	•	
				1	CURRY PK		
GARDEN	N VILLA			BLOOM	MINGTON, IN47403		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENC1)		DATE
		00 A.M. the blood					
	1 ^	7/76 with the Norvasc					
	held.	00 A M d. 11 1					
		00 A.M. the blood					
	1 ^	3/48 and the pulse was 73					
		orvasc and Atenolol held.					
		00 A.M. the blood					
	_	2/68 and the pulse was 74					
		orvasc and Atenolol held.					
		00 P.M. the blood					
	_	0/49 with the Lisinopril					
	held.	00.436.4.11.1					
		2:00 A.M. the blood					
	1 ^	4/77 and pulse was 61					
		orvasc and Atenolol held.					
		:00 A.M. the blood					
	_	1/69 and pulse was 67					
		orvasc and Atenolol held.					
		3:00 A.M. the pulse was					
	64 with the Aten						
		:00 P.M. the blood					
	1 ^	7/58 with the Lisinopril					
	held.						
		:00 P.M. the blood					
	1 ^	2/48 with the Lisinopril					
	held.						
		:00 P.M. the blood					
	_	0/58 with the Lisinopril					
	held.						
		:00 A.M. the blood					
	1 *	0/50 with the Norvasc					
	held.						
	On 11/24/10 at 8	3:00 A.M. the pulse was					

	COMPLETED 02/10/2011	
1100 S		
ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	1100 S BLOOM ID PREFIX	1100 S CURRY PK BLOOMINGTON, IN47403 ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155019	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION	COMI	(X3) DATE SURVEY COMPLETED 02/10/2011	
NAME OF P	PROVIDER OR SUPPLIER		1100 S	ADDRESS, CITY, STATE, ZIP COE CURRY PK IINGTON, IN47403	DE .		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APF DEFICIENCY)	CTION ULD BE PROPRIATE	(X5) COMPLETION DATE	

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155019	B. WIN			02/10/2011
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 1100 S CURRY PK BLOOMINGTON, IN47403			
(X4) ID PREFIX TAG F0441	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	F04	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY) It is the policy of Garden Villa	DATE
	Based on interview, observation, and record review, the facility failed to ensure nursing staff washed their hands or changed gloves according to facility policy while providing resident care for 2 of 30 sampled residents and 1 random resident reviewed for infection control			establish and maintain an infection control program designed to provide safe, sani and comfortable environment to help prevent the developme and transmission of disease a infection. Garden Villa submits following action as evidence or commitment to compliance wit regulatory requirements. I. Who corrective action(s) will be accomplished for those reside found to have been affected by the defienct practice? All staff to cared for the identified resident were in serviced on proper infection control practices. Resident #54 remains free from	and ent ent ent the fits h eat nts y hat tts	
	practices, a ensure a sh cleansed af random sho on 1 of 7 ur of 30. (Res	nd failed to ower chair was fter use for 1 of 1 owers observed nits, in a sample ident #74, 54, and Resident andom #32)			facility aquired infections. Resident #54 has been transferred to a different room the facility. Resident #74 has h bed linens and pillow changed and call light cleaned. Resider #27 remains free from facility aquired infection. Resident #2' has had all bed linens changed.Resident #32 remain free from facility aquired infections. The shower chair u by resident #32 was disinfecte on 2/7/11. II. How other residents having the potential be affected by the same defiecient practice will be identified and what corrective action(s) will be taken?All residents have the potential to affected by this practice. In service training was completed	nad nt 7 s sed d tto

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER:		(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
THIE TEAM	or coluction	155019	A. BUII B. WIN			02/10/2011	
NAME OF E	PROVIDER OR SUPPLIER	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE 1100 S CURRY PK BLOOMINGTON, IN47403				
(X4) ID PREFIX TAG	summary s (EACH DEFICIENT REGULATORY OR 1. On 02/0 p.m., CNA to wear glo of Resident was observe Resident #: tubing and Resident #: a sheet whit urine on it. observed to gloves or ve before usin (which had CNA's wai resident an resident his glasses.	54 and to handle ich "has a little " CNA #3 was not change wash her hands ig a gait belt been around the st) to transfer the d to hand the s cell phone and 07/11 at 2:20 #4 was observed		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) with all staff regarding infection control practices. Direct observation of nursing staff is being conducted randomly for proper infection control compliance. III. What measure will be put into place or what systemic changes will be made ensure the deficient practice on the recur? On going education and direct observation will continue to ensure proper infection control compliance. I how corrective action(s) will be monitored to ensure the deficient practice will not recur? Monthly report will be given to Quality Assurance regarding infection rates and results of direct observations. This will be an going report. V. Systemic changes will be completed by 3/2/11	es e to oes V. e ent v a	(X5) MPLETION DATE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		155019	A. BUI B. WIN			02/10/2011	
NAME OF F	PROVIDER OR SUPPLIEF	2		1100 S	DDRESS, CITY, STATE, ZIP CODE CURRY PK IINGTON, IN47403		
(X4) ID PREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES CH DEFICIENCY MUST BE PERCEDED BY FULL ULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
	transferring	g Resident #74					
	from the resident's						
	wheelchair	to her bed. CNA					
	#4 was obs	served to wear					
	gloves whi	le removing					
	Resident #	74's slacks and					
	adult brief and handling a wound dressing which had						
	fallen off the	he resident's					
	buttocks ar	ea. CNA #4 was					
	observed to	o not change					
	gloves or v	vash her hands					
	before plac	ing a pillow					
	under the r	esident's leg,					
	straighteni	ng the resident's					
		er the resident,					
		g the resident					
	her call lig	ht.					
		19/11 at 9:30					
	ĺ	#1 was observed					
	to wear glo	oves while					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155010		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 02/40/2044			
	155019		B. WIN	B. WING			02/10/2011	
NAME OF PROVIDER OR SUPPLIER GARDEN VILLA			STREET ADDRESS, CITY, STATE, ZIP CODE 1100 S CURRY PK BLOOMINGTON, IN47403					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE		(X5) COMPLETION DATE	
	providing of	care for Resident						
	#74. CNA	#1 was observed						
	to wash the	e resident's face						
	and hands	and to remove a						
	wet brief a	nd wash the						
	resident's b	oottom. CNA #1						
	was observed to not change							
	gloves or wash her hands							
	before straightening the							
	resident's blankets over the							
	resident, handing the							
	resident her call light, and							
	putting safety floor mats back in place. A policy titled "Handwashing/Hand Hygiene" was provided by the Director of Nursing (DON) on 02/10/11 at 10:40 a.m. The policy indicated, "Purpose: The							

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155019		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED 02/10/2011		
NAME OF PROVIDER OR SUPPLIER GARDEN VILLA			B. WING OZ/10/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 1100 S CURRY PK BLOOMINGTON, IN47403				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	purpose of	this procedure is					
	to provide	guidelines to					
	employees	for proper and					
	appropriate	e hand washing					
	and hygien	e techniques that					
	will aid in	the prevention of					
	the transmission of						
	infectionsObjective: To						
	prevent and to control the						
	spread of infectious						
	diseasesThe use of gloves						
	does not replace						
	handwashing. If hands are						
	not visibly soiled, use an						
	alcohol-based hand rub for						
	all the following						
	situationsbefore direct contact with						
	residents	Before moving					
	from a contaminated body site of a clean body site						
	during resid	dent careAfter					

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING COMPL		(X3) DATE SURVEY COMPLETED 02/10/2011
155019		B. WING	ADDRESS, CITY, STATE, ZIP CODE	02/10/2011	
NAME OF F	PROVIDER OR SUPPLIER	8	l	CURRY PK	
GARDEN			BLOOM	MINGTON, IN47403	
(X4) ID PREFIX		STATEMENT OF DEFICIENCIES ICY MUST BE PERCEDED BY FULL	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	DATE DATE
	contact wit	th resident's			
	intact skin.	"			
					<u> </u>

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A PLUI DING			COMPLETED	
		155019	A. BUILDING			02/10/2011	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER							
GARDEN VILLA				l	CURRY PK MINGTON, IN47403		
GARDEN	VILLA			BLOOK	MINGTON, IN47403		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)	DATE	
F0441			F04	41	It is the policy of Garden Villa	to 03/02/2011	
	4. During obser	vation of pericare for			establish and maintain an		
	_	02/09/11 at 9:25 A.M.,			infection control program		
		Nursing Assistant] #5 was			designed to provide safe, sani and comfortable environment		
	=	gloves and provide			I .	l l	
		• •			to help prevent the development and transmission of disease and		
	•	right gloved hand. CNA			infection.Garden Villa submits		
		to transfer Resident #27			following action as evidence of its		
	to the bed, touch	ing the resident's gown			commitment to compliance with		
	and bed linens w	vith the gloved right			regulatory requirements.l. What		
	hand. During an interview with CNA #5, on				corrective action(s) will be		
					accomplished for those reside		
					found to have been affected be the defienct practice? All staff to		
	1						
	02/09/11 at 9:30 A.M., she indicated, "We change gloves before and after care."				cared for the identified resider were in serviced on proper	ils	
					infection control practices.		
	5. Following observation of a shower provided by CNA #6 to Random Resident #32, on 02/07/11 at 2:15 P.M., CNA #6 failed to disinfect the shower room.				Resident #54 remains free fro	m	
					facility aquired infections.		
					Resident #54 has been		
					transferred to a different room	in	
					the facility. Resident #74 has I		
					bed linens and pillow changed		
					and call light cleaned. Resider	nt	
	The policy and Procedure for Shower/Tub				#27 remains free from facility	_	
Bath provided by the DoN [Director of Nursing], on 02/09/11 at 12:30 P.M., indicated, "Infection Control Protocol and		the DoN [Director of			aquired infection. Resident #2 has had all bed linens	′	
		09/11 at 12:30 P.M.,			changed.Resident #32 remain		
				free from facility aquired			
	Safety5. After	completion of the			infections. The shower chair u	sed	
	procedure, clean,equipment and				by resident #32 was disinfected		
	supplies in the appropriate manner as identified per facility infection control				on 2/7/11. II. How other		
					residents having the potential	to	
					be affected by the same		
	policy."				defiecient practice will be		
					identified and what corrective		
	During an interview with CNA #6, on				action(s) will be taken?All residents have the potential to be		
	_	35 P.M., she indicated, "I'm			affected by this practice. In		
	done with the shower."				service training was completed	d	
	done with the sin				To the daming was completed	_	

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155019			A. BUILDING CO			(X3) DATE S COMPL 02/10/2	ETED
NAME OF PROVIDER OR SUPPLIER GARDEN VILLA			B. WING 02/10/2011 STREET ADDRESS, CITY, STATE, ZIP CODE 1100 S CURRY PK BLOOMINGTON, IN47403				
(X4) ID PREFIX TAG	SUMMARY S	STATEMENT OF DEFICIENCIES SCY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PR	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)		(X5) COMPLETION DATE
	02/07/11 at 2:50 didn't clean or spare supposed to We spray disinfe	riew with CNA #6, on P.M., she indicated, "I bray off the chair. CNA's clean it between residents. ectant with the spray ff, then spray it off."			with all staff regarding infection control practices. Direct observation of nursing staff is being conducted randomly for proper infection control compliance. III. What measur will be put into place or what systemic changes will be madensure the deficient practice of not recur?On going education and direct observation will continue to ensure proper infection control compliance. I'l How corrective action(s) will be monitored to ensure the deficient practice will not recur?Monthly report will be given to Quality Assurance regarding infection rates and results of direct observations. This will be an agoing report. V. Systemic changes will be completed by: 3/2/11	es e to oes V. e ent r a	